Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

The mental health services described in this manual are provided through the Expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for children under 21 years of age. Mental health services include therapeutic (bio-psycho-assessment, individual, family, and group therapy, day treatment, ~~case management~~) and evaluative (psychological, developmental, and neuropsychological evaluation) services. All services must be medically necessary. Services that require prior authorization must be authorized by DOM prior to service delivery.

A provider requesting certification as a Medicaid-authorized provider must complete and submit a provider enrollment packet. ~~All~~ Enrollment forms must be signed and returned to the fiscal agent along with all requested documentation. When ~~all information~~ the enrollment packet is received it will be reviewed for completeness and, if complete, submitted to the Executive Director of DOM for approval or disapproval. If approved, the enrollment forms will be sent to the fiscal agent so that a Medicaid provider number may be assigned. If the Executive Director disapproves, the ~~provider~~ applicant will be notified in writing and the reasons for the disapproval will be clearly stated.

A mental health service provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between their usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary (except in cases of retroactive eligibility). Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: X Current:	Date: ~~10/01/02~~ Date: 03/01/07
Section: Community-Based Mental Health Services Subject: Provider Categories	Section: 21.02 Pages: 2 Cross Reference: 21.06 Therapeutic Services 21.16 Prior Authorization 22.0 Mental Health/ Psychiatry	

Any providers of Community-Based Mental Health Services must be ~~Medicaid eligible~~ an approved Medicaid provider and qualified as indicated to provide the services listed:

Nurse Practitioner: Individual with a minimum of a Master's degree who is licensed to practice, under the supervision of a physician, as a nurse practitioner under state law.

- Nurse Practitioners are authorized under EPSDT to provide limited developmental evaluations (developmental screenings) if they possess the necessary training, experience and expertise to be able to provide such evaluation within the scope of their license.

- Services, which may be provided by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP), are covered in Section 22, Mental Health/ Psychiatry.

Physician: ~~Individual licensed under State law to practice medicine.~~ An individual (medical doctor or doctor of osteopathy) licensed under State law to practice medicine.

Developmental Pediatrician: A physician who has specialized training in developmental pediatrics. Developmental pediatricians may provide developmental evaluations.

Psychiatrist: A physician who is ~~board eligible~~/board certified in psychiatry or who has successfully completed an approved residency in psychiatry. Psychiatrists who wish to provide day treatment must follow the ~~process for prior authorization outlined in Section 21.16.~~ guidelines for day treatment and obtain prior authorization from DOM.

Refer to Section 21.06, Therapeutic Services for guidelines related to day treatment and Section 21.16, Prior Authorization in this manual. Mental health services, which may be provided by a psychiatrist, are covered in Section 22, Mental Health/Psychiatry.

~~**Private Mental Health Centers (PMHC)**: PMHC's are private entities that have been certified by the Mississippi Department of Mental Health as meeting its standards for the delivery of mental health services in the community.~~

~~Private MHC's are authorized to provide any of the following services IF they are delivered in accordance with the requirements governing the particular service as outlined in this manual:~~

- ~~psychological evaluations~~
- ~~bio-psycho-social assessments~~
- ~~individual, family and group therapy~~
- ~~day treatment~~
- ~~case management~~

Psychologist: An individual licensed under State law to practice psychology independently. Psychologists are authorized to provide any of the following services:

- psychological evaluations, when prior authorization is requested/received from DOM
- bio-psycho-social assessments
- individual, family and group therapy
- day treatment, when provided as outlined in Section 21.06 and prior authorization is is requested/received from DOM for each beneficiary who participates.

Psychologists with appropriate training, experience, and expertise in neuropsychology or developmental psychology may provide assessments in those areas.

Social Worker: An individual licensed under State law as a licensed certified social worker (LCSW). Social workers are ~~approved~~ authorized to provide any of the following services:

- bio-psycho-social assessments;
- individual, family and group therapy
- day treatment, when provided as outlined in Section 21.06 and prior authorization is requested/received from DOM for each beneficiary who participates.

Mental Health Group: One or more approved Medicaid Providers listed in this section who have been through the provider enrollment process as a group.

Background & Information Gathering: The first portion of the psychological evaluation. During this meeting, the psychologist meets with the child's family and the child to determine the medical necessity of testing and gather relevant background information.

Billing Provider: The entity (individual or group) who bills and receives payment for services delivered to Medicaid beneficiaries.

Collateral: A person with whom contact is necessary to ensure that the best interests of the child are served, but whose relationship with the child is of a secondary rather than a primary nature. Examples of collaterals include, but are not limited to, teachers, youth court counselors, and health care professionals. Collateral contacts are allowed only as a part of case management services and during the background and information gathering portion of the evaluation process. Collateral contacts are eligible for reimbursement by Medicaid only when they are done face-to-face.

CFR: Code of Federal Regulations.

DSM: Diagnostic and Statistical Manual.

Family: Members of the child's ~~biological~~ family and others (guardian or other caregivers, such as the Mississippi Department of Human Services staff and foster family members) with whom the child has a family-like relationship.

Feedback Session: The third and final section of the psychological evaluation, during which the psychologist meets face to face with the referral source (if possible), the child's family, and when appropriate, the child to review evaluation results and recommendations.

Medical Necessity: The standard of appropriateness which any mental health service must meet in order to be eligible for reimbursement through Medicaid. In order to be "medically necessary," mental health services must be (1) consistent with the diagnosis or treatment of the child's condition or illness; (2) in accordance with the standards of good medical practice; (3) required for reasons other than the convenience of the child, the child's family member(s), or the provider; and (4) the most appropriate level of mental health services which can be safely and efficiently provided to the child in a community-based setting.

Prior Authorization (PA): ~~Some services must be authorized by DOM as medically necessary prior to service delivery in order for the service to be eligible for reimbursement by DOM. In the area of community-based mental health services, those services requiring PA are:~~

- ~~evaluative services for all children~~
- ~~day treatment services for all children~~
- ~~case management for all children~~
- ~~all psychotherapy services for children younger than three (3) years of age, and~~
- ~~psychotherapy services for children ages 3-20 which extend beyond the standard allowed each child (Section 21.15, Service Standards).~~

~~Prior authorization may be obtained through the submission of an authorization request to DOM by a qualified Medicaid provider (Section 21.16, Prior Authorization).~~

Prior Authorization (PA): Refers to the verification of medical necessity for a particular procedure or service which must be obtained from DOM prior to the delivery of that procedure/service in order for it to be eligible for reimbursement by DOM. It is the Medicaid provider's responsibility to secure prior authorization from DOM before delivering any service which requires PA. (Section 21.16, Prior Authorization).

PRTF: Psychiatric Residential Treatment Facility.

Referral Question: The reason for which a psychological evaluation is being requested. The psychologist is responsible for determining the appropriateness of testing to address the referral question. In those instances in which a referral question can be addressed through other means, the psychologist should review these issues with the referral source and assist in determining an appropriate course of action.

SED (Serious Emotional Disturbance): A descriptive category which identifies any person from birth up to age 21 who meets one of the eligible (DSM) diagnostic categories and whose identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills.

Servicing Provider: The mental health professional who provides mental health services to a Medicaid beneficiary.

In order to be eligible for Medicaid reimbursement, all services discussed in this policy section must meet the following general requirements:

- Services must be provided in a community-based setting.
- All services must be personally and directly provided by the person ~~who requests reimbursement for the service~~ who is identified as the "servicing provider".
- Services must be based on beneficiary need and not the convenience of the beneficiary, the beneficiary's family or the provider.
- A provider may bill only for the actual time spent in service delivery.
- Only DOM can ~~initiate, in writing,~~ provide any interpretations, clarifications, or exceptions to the Medicaid rules, regulations, or policy and will do so only in writing.

~~Medicaid reimbursement is not available for and should not be sought by the provider when any of the following conditions exist:~~

- In accordance with federal regulations, telephone contacts are not eligible for Medicaid reimbursement.

- Educational interventions of an academic nature (e.g., tutoring sessions) are not eligible for Medicaid reimbursement.

- In accordance with federal regulations, failed and/or canceled appointments are not eligible for Medicaid reimbursement, regardless of the circumstances, and cannot be billed to the Medicaid beneficiary (HCFA Transmittal Notice MCD-43-94).

- Medicaid will not reimburse more than once for the same service provided to any beneficiary on any given date, regardless of the setting(s) in which the service was provided. Federal matching funds are not available for services that are considered to be duplications of service. It is Mississippi Medicaid policy that if the federal match is not available, it is not covered in the Medicaid program.

  For example, if a child is seen in a community mental health center for individual therapy and is seen for individual therapy later that same day by an LCSW in independent practice, only one of these services will be eligible for reimbursement by Medicaid. It is the provider's responsibility to coordinate services for the child/adolescent with the parent/family member.

- Community-based mental health services described in this manual are not eligible for reimbursement when a beneficiary is in a Medicaid-covered inpatient facility (e.g., medical hospital, freestanding acute psychiatric facility, psychiatric residential treatment facility, or nursing facility). Providers of Medicaid-covered inpatient services are reimbursed on a per diem basis, and that fee is considered to be an all inclusive rate for room and board and any ancillary services the patient may need, including therapeutic and evaluative services as defined in this section. The inpatient provider may recommend that a patient should receive therapeutic and evaluative services during the inpatient stay, but if an outside provider provides the service, the inpatient provider is responsible for reimbursing that provider.

- Paperwork, unless completed during the session and relevant to the treatment goals, is not eligible for Medicaid reimbursement. Time spent completing a Plan of Care form is not eligible for Medicaid reimbursement.

Psychotherapy Services

Psychotherapy Services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a mental health therapist and a client (an individual, family or group) in which a therapeutic relationship is established to help resolve symptoms of the child's mental and/or emotional disturbance. Psychotherapy services include bio-psycho-social assessment, individual therapy, family therapy and group therapy.

- A **bio-psycho-social assessment** is the securing, from the child and/or his/her family, of the child's presenting problem(s), problem history, family background, medical history, current medication(s), educational/vocational achievement, history of previous mental health treatment, source of referral or other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the child.

  Even though assessment is an ongoing process that is inseparable from treatment, there are points (primarily intake or initiation of treatment) when a comprehensive "review of systems" ~~impinging upon the life of the child is appropriate~~ in the child's life is appropriate. It is this comprehensive assessment that is referred to as "bio-psycho-social assessment."

  A bio-psycho-social assessment is eligible for reimbursement by Medicaid at the beginning of a treatment relationship between a child and a mental health provider or when renewing treatment after a lapse of six (6) months or longer. ~~***Until a procedure code becomes available for bio-psycho-social assessment, it should be billed as family therapy or individual therapy, as appropriate.***~~

- **Individual therapy** is defined as one-on-one psychotherapy that takes place between a mental health therapist and a child.

- **Interactive individual therapy** is defined as one-on-one psychotherapy using non-verbal communication and/or physical aids that takes place between a mental health therapist and a child. It should be provided to children who have not yet developed or have lost their expressive communication skills to explain symptoms and their response to treatment or do not have the cognitive ability to understand the mental health therapist if ordinary adult language is used.

- **Family therapy** is defined as psychotherapy that takes place between a mental health therapist and a child's family members, with or without the presence of the child. Family therapy may also include others (Mississippi Department of Human Services staff, foster family members, etc.) with whom the child lives or has a family-like relationship.

- **Group therapy** is defined as psychotherapy that takes place between a mental health therapist and no more than eight (8) children at the same time. It is expected that most psychotherapy groups will consist of at least four (4) children. However, since particular circumstances (e.g., absences) could prohibit a group of that size, the minimum number of children allowed for group psychotherapy is two (2). Possibilities include, but are not limited to, groups that focus on anger management and/or conflict resolution, survival of sexual abuse, adjusting to divorce in the family, coping with ADHD, social skills training, self-esteem enhancement, etc.

- **Interactive group therapy** is defined as psychotherapy using non-verbal communication and/or physical aids that takes place between a mental health therapist and no more than six (6) children at the same time. It is expected that most interactive psychotherapy groups will consist of at least four (4) children. However, since circumstances could prohibit a group of that size, the minimum number of children allowed for interactive group therapy is two (2).

Psychotherapy services are eligible for Medicaid reimbursement when at least one of the following conditions ~~apply~~ applies:

- The child is experiencing significant psychosocial or environmental stressors and would benefit from added support.
- The child is at risk for more restrictive interventions and/or placements if intervention is not ~~made~~ provided.
- Strengthening the child's coping and/or social skills would likely help prevent deterioration of the child's mental status in the future.
- There is an identified treatment need that is recognized by the child.

Psychotherapy services are **NOT** eligible for reimbursement by Medicaid when any of the following conditions apply:

- ~~The child does not have the cognitive skills to benefit from therapy.~~
- The child is unable to benefit from therapy due to cognitive impairment, developmental delays or any other reason;
- The child has communicated verbally or behaviorally that s/he is not interested in participating in therapy and has not responded to attempts to adapt therapy to meet his/her needs.
- Family therapy sessions are billed for multiple siblings in a family on the same day. It is expected that one family therapy session per family per day is as much therapy as any family can benefit from. For example, if three siblings—all Medicaid beneficiaries—are seen together in a family session, that is **one** family session and is billed under **only one** beneficiary's Medicaid ID number.
- It is an educational intervention of an academic nature (e.g. tutoring).
- It is billed for time spent completing the Plan of Care forms.

Day Treatment

Day Treatment is a behavioral intervention program, provided in the context of a therapeutic milieu, which provides children/adolescents with serious emotional disturbances (SED) the intensity of treatment necessary to enable them to live in the community. Day Treatment is the most intensive outpatient program available to children and adolescents. ~~Day Treatment must meet the program standards outlined by the Mississippi Department of Mental Health.~~

Day Treatment is eligible for reimbursement by Medicaid when all of the following conditions exist:

- It is provided by ~~a qualified~~ an approved Medicaid provider through a program that has been certified by the Mississippi Department of Mental Health (DMH);

- It is provided in accordance with the minimum standards for day treatment set by DMH;
- It is approved for provision to a beneficiary through the prior authorization process (Section 21.16, Prior Authorization) AND.
- It is provided as an alternative to acute psychiatric hospitalization or residential treatment **OR** as a transition between acute or residential treatment and less intensive outpatient treatment.

Day treatment is **NOT** eligible for reimbursement by Medicaid when:

- Prior authorization has not been received from DOM;
- It is provided on the same day as group therapy.

~~**Case Management Services**~~

~~**Case Management Services** are community-based services that provide information/referral, supportive counseling, and resource coordination to the beneficiary, his/her family members and/or collateral support persons. Case Management Services are directed towards helping the child attain his/her highest level of functioning in a community-based setting. Activities include consultation professional advice and support) provided to a child's teachers, guidance counselors, community support providers, court systems, etc., and/or crisis intervention with the child and/or his/her family members.~~

~~Case Management is eligible for reimbursement by Medicaid when all of the following conditions exist:~~

- ~~It is provided by a qualified Case Manager through a program that has been certified by the Mississippi Department of Mental Health;~~
- ~~It is approved for provision to a child through the Prior Authorization process (Section 21.16, Prior Authorization); **and**~~
- ~~It is provided in accordance with the minimum standards as outlined by the Mississippi Department of Mental Health.~~

~~Case Management is **NOT** eligible for reimbursement by Medicaid when:~~

- ~~It is provided simultaneously with another service (e.g., during group therapy or Day Treatment)~~

Evaluative Services are those services which provide mental health assessments of beneficiaries. All evaluations require prior authorization by DOM in order to be eligible for reimbursement ~~(Section 21.16, Prior Authorization)~~. Refer to Section 21.16, Prior Authorization of this manual.

Evaluative Services are composed of three parts:

- **Background and Information Gathering** during which information is gathered to best address the referral question and determine the course of testing,
- **Evaluation** during which the testing is completed, and
- **Feedback** during which test results and recommendations are reviewed with the referral source (if possible), the child's family, and when appropriate, the child.

Psychological Evaluation

A **psychological evaluation** is the assessment of a beneficiary's cognitive, emotional, behavioral and social functioning by a licensed psychologist using standardized tests, interviews and behavioral observations.

A psychological evaluation may be eligible for Medicaid reimbursement when one or more of the following conditions exist:

- There is a history of unexplained treatment failures.
- There are questions regarding diagnosis and/or treatment that a psychological evaluation might help to answer.
- Such evaluation is required by DOM for admission to a psychiatric residential treatment facility (PRTF).
- When a child is initially placed into custody of the Mississippi Department of Human Services. In order to be eligible for reimbursement, the evaluation must be completed within 90 days of the custody order.

Examples of reasons a psychological evaluation may be eligible for reimbursement include, but are not limited to:

- The need to confirm or rule out the existence of a major diagnosis, such as depression, psychosis, or Attention Deficit Hyperactivity Disorder (ADHD) when behavioral observation and history supports the suspected diagnosis.
- The existence of a pattern of inability to learn, but not to the extent that the child qualifies for evaluation for Special Education services.

- The need to assess a child's potential for success in a certain type of program.

A psychological evaluation is **NOT** eligible for reimbursement through Medicaid when any of the following conditions apply:

- It is provided as a routine procedure or requirement of any program or provider, including pre-commitment hearings;
- It is to determine educational needs/problems when such assessment is the responsibility of the school system in which the child is enrolled;
- It is within one year of a previous psychological evaluation, unless necessary for admission to a Medicaid-certified PRTF ~~(Section 18.12)~~ or if needed to assess progress in a child with an evolving condition (i.e., head injury, severe depression). Refer to Section 18.03, Mental Health/ Psychiatric Residential Treatment Facility in this manual.

In order for a psychological evaluation to be eligible for Medicaid reimbursement, the psychologist completing the psychological evaluation must ensure that all of the following occur:

- Psychological testing is indicated by the referral question. If it is not, it is the responsibility of the psychologist to educate the referral source as to those circumstances in which testing is or is not indicated.
- An initial session is held with the child and child's family before any testing is initiated. The purpose of this session is to determine the medical necessity of psychological evaluation and to gather background information. Collateral contact may be included in the background and information gathering session, and the time spent with those collateral contacts is eligible for Medicaid reimbursement only when that contact is face-to-face. If it becomes apparent during the session that the child and/or family would benefit from certain strategies/interventions (e.g., bibliotherapy, behavioral approaches for children with attention difficulties), these interventions should be implemented and their effectiveness evaluated before the necessity of testing is reconsidered. ~~This session can be scheduled immediately prior to the evaluation session (refer to Section 21.15 for billing guidelines for Background & Information gathering).~~ **Though part of the evaluation process, the background and information gathering session should be billed as either a bio-psycho-social assessment or family therapy (with or without the beneficiary, as appropriate).**
- If/when testing is indicated; the testing process and the written report document the medical necessity, adequately address the referral question, and reflect an understanding of the background strengths, values and unique characteristics of the child and family.
- The psychologist has appropriate training, experience and expertise to administer, score and interpret those instruments used.
- The instruments used are psychometrically valid and appropriate to the referral question, the child's age and any special conditions presented by the child and/or the testing situation. In those instances in which more than one instrument could be used (e.g., IQ testing), the psychologist chooses the most psychometrically sound one unless otherwise indicated by the unique characteristics of the test-taker (e.g., the child is non-English speaking, physically unable to manipulate materials).
- A written report is generated within thirty (30) calendar days of completion of the assessment. However, if the child's treatment needs indicate an earlier report deadline, the report is generated as soon as possible. The report synthesizes the information gathered through interviews,

observation, and standardized testing, including a discussion of any cautions related to testing conditions or limitations of the instruments used.

- The written report provides practical recommendations for those working with the child. These recommendations should reflect recognition of the child's and family's strengths as well as their areas of need.

- If computer-generated scoring or interpretation reports are used as one source of data, they must be integrated into the report as whole. Reports that include computer generated feedback without this integration are considered unacceptable.

- Unless doing so would present a hardship to the child and family, the child's family and, when appropriate, the child are provided with face-to-face (when possible) verbal feedback regarding test results, interpretation and recommendations within fourteen (14) calendar days of the written report. The referral source is included if requested at the time of the referral. The child's family and the child shall be given adequate opportunity to ask questions and give their input regarding the evaluation feedback. If face-to-face feedback is not possible, feedback is provided through alternative means. ~~A summary of this meeting shall be documented in writing (refer to Section 21.15 Table A for billing guidelines for Feedback).~~ However, part of the evaluation process, the feedback session should be billed as family therapy, with or without the beneficiary present, as appropriate.

- Concrete plans are made for follow-up based on evaluation recommendations and feedback from the referral source, the family and, when appropriate, the child (e.g., therapy appointment is made, the family is given information about mentoring programs), and these plans are documented in writing.

- Information obtained from collateral contacts is included in the report.

Developmental Evaluation

A **developmental evaluation** is the assessment of the current cognitive, social and motor functioning of children younger than three years of age or children with such severe mental or physical disabilities that standardized intellectual assessment is not possible. A developmental evaluation may be:

- limited (e.g., Developmental Screening Test II, Early Language Milestone Screen);

- extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development).

A developmental evaluation is eligible for reimbursement by Medicaid when all of the following conditions apply:

- It is conducted by a physician or a psychologist with knowledge/expertise in developmental evaluation.

- It would assist in treatment program planning for a child less than three years of age or a child with a severe disability.

- There exists the need to determine the existence of a major diagnosis; the child's inability to learn or to determine the child's potential success in a certain type program and the child has been unable to respond to traditional instruments.

Developmental evaluation is **NOT** eligible for reimbursement when any of the following conditions apply:

- The referral question may be adequately answered through behavioral observation and family interviews.

- Standardized intellectual assessment is indicated and the child is three years or older with no severe disabilities.

In addition to the assurances for administering psychological evaluations listed in this section, the provider administering the developmental evaluation must ensure that the limitations of the psychometric properties and predictive validity of such instruments are considered when synthesizing information and giving written and verbal feedback regarding results.

Neuropsychological Evaluation

A **neuropsychological evaluation** is testing/assessment which is intended to describe and diagnose the neurocognitive effects of medical disorders which impinge directly or indirectly on the brain. A neuropsychological evaluation is an enhanced psychological evaluation, consisting of a psychological evaluation expanded to include special features to assess specific neurological functions. Therefore it may be billed **instead of** but **not simultaneous with** a psychological evaluation.

A neuropsychological evaluation is defined as comprehensive neuropsychological testing (e.g., Halstead-Reitan, Luria,) which consists primarily of individually administered ability tests that comprehensively sample domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem-solving, sensorimotor functions, constructional praxis, etc.). Neuropsychological testing does not rely on self-report questionnaires, rating scales or projective techniques, but rather employs procedures which are objective and quantitative in nature and require the patient to demonstrate directly his/her level of competence in a particular cognitive domain.

Neuropsychological screening is considered to be a part of the neuropsychological evaluation and therefore cannot be provided as a discrete service.

A neuropsychological evaluation may be eligible for reimbursement by Medicaid when at least one of the following conditions apply:

- Other interventions have been attempted but failed;

- Previous psychological evaluation indicates neuropsychological deficits with supporting justification;

- There is evidence of brain involvement;

- The results are used in treatment planning and placement decisions.

Neuropsychological evaluations are **NOT** eligible for reimbursement by Medicaid when any of the following conditions apply:

- The only question is to rule out ADHD;

- Previous testing did not support the suspicion of organic involvement.

In addition to those responsibilities outlined in Section 21.01, the psychologist administering the neuropsychological evaluation must ensure that both of the following conditions apply:

- S/he is adequately trained to administer, score and interpret neuropsychological instruments;

- Feedback from medical reports and tests are integrated into the evaluation and recommendations.

Treatment Plan

A treatment plan must be developed and implemented for each beneficiary no later than the date of the third therapy session and must include, at a minimum:

- a multi-axial diagnosis
- identification of the child's and/or family's strengths
- identification of the clinical problems, or areas of need, that are to be the focus of treatment
- treatment goals for each identified problem
- treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement
- specific treatment modalities and/or strategies that will be employed to reach each objective
- the date of implementation and signature of the provider.

Treatment plans must be kept in the case record and must be reviewed and revised as needed, or at least every three (3) months. Each review must be verified by the dated signature of the provider and beneficiary. The Physician, Nurse Practitioner, Psychologist, and Clinical Social Worker must sign the treatment plan for the services which he/she will provide to the beneficiary.

Services

A clinical note for each service provided must be in the case record. ~~and must:~~ The clinical note must include the following documentation:

- ~~include~~
- the date of service
- type of service provided
- the length of time spent delivering the service
- who received or participated in the service
- who provided the service
- a brief summary of what transpired in the session.
- relate to the goals and objectives established in the treatment plan.
- be authenticated by the signature of the person who provided and documented the service. ~~Any note that is "signed" by computer must be initialed by hand.~~

Evaluation reports must be dated and signed by the provider who conducted the evaluation.

Documentation of evaluations must also include the amount of time spent in assessment/testing and the amount of time spent preparing a report.

All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under

the program and, upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. DOM, and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the provider. If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider. A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Refer to Section 7.03, Maintenance of Records for additional documentation requirements.

- ~~Case management notes must relate to the case management service plan as well as the treatment plan.~~
- ~~Travel time for case management services must be documented separately from service delivery time.~~

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Revised: X Current:	Date: ~~10/01/02~~ Date: 03/01/07
Section: Community-Based Mental Health Services Subject: ~~Service Standards~~ Limitations to Service Provision	Section: 21.15 Pages: 2 Cross Reference: 7.03 Maintenance of Records 21.06 Therapeutic Services 21.16 Prior Authorization	

~~Service standards~~ ~~identify the maximum number of units (of any particular service) that are eligible for reimbursement when provided to a child within a given time frame, unless an exception to the standard has been justified by the provider and approved by DOM through the PA process outlined in Section 21.16.~~

~~Service Units~~

~~Service units are used to calculate how any particular service may be billed for reimbursement.~~

~~For all **therapeutic services** (psychotherapy, day treatment) and **case management services**, one unit of service is equal to 15 minutes of face-to-face service delivery. Therapeutic services may be provided to a child through contact with the child and/or his/her family members. Case management services may be provided to a child through contact with the child, his/her family members and/or collateral support persons.~~

~~For **evaluative services**, service units are determined by adding the amount of time spent in assessment and the time spent preparing a report. Evaluative service units are designated as follows:~~

~~Service~~	~~Procedure Code~~	~~Service Unit~~
~~Psychological Evaluation~~	~~96100~~	~~1 hour~~
~~Development Evaluation, Limited~~	~~96110~~	~~1 service~~
~~Developmental Evaluation, Extended~~	~~96111~~	~~1 service~~
~~Neuropsychological Evaluation~~	~~96117~~	~~1 hour~~

~~Place of Service~~

~~Each service has types of allowable physical locations that are designated as authorized sites for provision of that particular service. The following Place of Service (POS) codes should be used when billing to indicate where the service was provided:~~

~~2 = Outpatient Hospital~~
~~3 = Office~~
~~4 = Beneficiary's Home~~
~~5 = Private Mental Health Center (MHC)~~
~~0 = School/Other~~

~~See Tables A and B in this section for the authorized sites for the provision of community-based mental health services.~~

~~Daily Standard~~

~~The daily standard indicates the maximum number of units of any particular service provided per child per day that are eligible for reimbursement by Medicaid, unless an exceptional need has been documented and an exception to the standard approved by DOM through the Prior Approval process (Section 21.16).~~

~~Yearly Standard~~

~~The yearly standard indicates the maximum number of units of any particular service provided per child per fiscal year (July 1 - June 30) that are eligible for reimbursement by Medicaid, unless an exceptional need has been documented and an exception to the standard approved by DOM through the Prior Approval process (Section 21.16).~~

Service Standards: Tables A & B

The services in Table A are those that are available for use per child per fiscal year (July 1- June 30) without need for prior authorization by DOM. If any of these services are needed beyond the amount specified here, the additional services must be authorized as medically necessary prior to their provision in order for them to be eligible for reimbursement through Medicaid. Prior authorization for the additional services may be requested through the PA process identified in Section 21.16.

TABLE A

Service	Procedure Code	Payment Rate per Unit	Daily Standard	Allowable Place of Service Codes	Yearly Standard
Individual Therapy	W3305	$13.00	6 units	2,3,4,5,0	144 units
Family Therapy Background & Information Feedback	W3310	$13.00	6 units	2,3,4,5,0	96 units
Group Therapy	W3315	$5.00	8 units	2,3,5,0	160 units

The services in Table B are those that require prior authorization by DOM **before** they may be provided. If prior authorization is requested by the provider and approved by DOM (through the PA process outlined in Section 21.16), the service will be made available in the amount indicated below per fiscal year. If further service is needed beyond the standard amount, further justification must be submitted as outlined in Section 21.16.

TABLE B

Service	Procedure Code	Payment Rate per Unit	Daily Standard	Allowable Place of Service Codes	Yearly Standard
Psychological Evaluation	96100	$85.68	4 units	2,3,5,0	4 units
Developmental Evaluation, Limited	96110	$38.87	1 units	2,3,5,0	1 units
Developmental Evaluation, Extended	96111	$55.13	1 units	2,3,5,0	1 units
Neuropsychological Evaluation	96117	$100.00	10 units	2,3,5,0	10 units
Case Management	W9405	$8.75	96 units	3,4,5,0	576 units
Day Treatment	W3320	$2.67	25 units	3,5,0	N/A

All services, whether provided through the standard service allotment or through Prior Authorization by DOM, must meet the DOM standard for medical necessity. DOM will review clinical records periodically on a random-selection basis to verify, among other things, that medical necessity exists.

There are several factors, which dictate the quantity of services, which may be provided within any given time frame.

Maximum Units identifies the maximum number of service units within any of the following categories of service that are eligible for Medicaid reimbursement on any given day.

- Individual Therapy: Only one individual therapy service (regardless of the length of the session) per beneficiary per day is eligible for reimbursement.

- Family Therapy: Only one family therapy service per beneficiary per day is eligible for reimbursement, whether the beneficiary is present for the service or not. If the beneficiary is present for any part of the session, it is considered "family therapy with the beneficiary present". Family therapy cannot be provided on the same day as a bio-psycho-social assessment.

- Group Therapy: Up to two (2) units of group psychotherapy per beneficiary per day may be eligible for reimbursement when:
    1. two distinct sessions, each having mutually exclusive goals and objectives, are provided, **AND**
    2. two sessions per day are medically necessary, **AND**
    3. two sessions per day are appropriate and in accordance with good practice standards, **AND**
    4. both sessions are provided by the same mental health professional, **AND**
    5. documentation in the clinical record substantiates that the above criteria were met.

- Bio-psycho-social Assessment: Only one bio-psycho-social assessment service per beneficiary per day is eligible for reimbursement. This service cannot be provided on the same day as family therapy. See section 21.06, Therapeutic Services, for further guidelines on the provision of this service.

- Psychological Evaluation: Psychological evaluation service units are calculated on an hourly basis. The current number of units per beneficiary, which are eligible for reimbursement on any given day, may be found on the website listed below.

- Neuropsychological Evaluation: Neuropsychological evaluation service units are calculated on an hourly basis. The current number of units per beneficiary, which are eligible for reimbursement on any given day, may be found on the website listed below.

- Developmental Evaluation: Only one developmental evaluation (whether limited or extended) per beneficiary per day is eligible for reimbursement.

- Day Treatment: Day treatment service units are calculated on an hourly basis. The current number of units per beneficiary, which are eligible for reimbursement on any given day, may be found on the website listed below.

Detailed current information on the above services may be found on the DOM website at www.dom.state.ms.us.

The website will provide a link to "Fee Schedules for Medicaid Provider Services". Once this link is accessed the provider should look for "Billing Guidelines for Community-Based Mental Health Services, Section 21".

Duplication of Service refers to the provision of the same service to the same beneficiary by the same or a different provider on the same day. For example, if a child is seen in a community mental health center for individual therapy and is seen for individual therapy later that same day by an LCSW or psychologist in independent practice, only one of these services will be eligible for reimbursement by Medicaid. Likewise, individual therapy provided by a mental health therapist and individual therapy with medication management provided by a psychiatrist in the same clinic (or a different one) would be considered a duplication of services and only one of the two services would be eligible for reimbursement.

In all cases where duplicate service claims have been filed, the claim that is filed first is the one that will be paid. If the beneficiary is receiving mental health services at more than one location from more than one provider, it is each provider's responsibility to coordinate those services with the beneficiary or his/her family members in order to avoid service duplication.

Yearly Service Standards identify the maximum quantity of services per beneficiary under the age of 21 that are eligible for reimbursement within a fiscal year. Service standards, as well as procedure codes for each service and other details, which pertain to billing, is all subject to change. Current billing guidelines can be found on the DOM website at www.dom.state.ms.us. The website will provide a link to "Fee Schedules for Medicaid Provider Services". Once this link is accessed the provider should look for "Billing Guidelines for Community-Based Mental Health Services, Section 21".

If additional services beyond those identified in the service standards are medically necessary within the same fiscal year, the provider may request additional service units from DOM through the prior authorization process outlined in Section 21.16.

Definition

Prior Authorization (PA) refers to the verification of medical necessity for a particular procedure or service which must be obtained from DOM prior to the delivery of that procedure/service in order for it to be eligible for reimbursement by DOM. It is the Medicaid Provider's responsibility to secure prior authorization from DOM before delivering any service which requires PA.

Mental Health Services Requiring PA

In the area of Mental Health Services, those services which require PA are as follows:

- All evaluations (psychological, developmental, neuropsychological) for all beneficiaries. The preparatory (Background/Information Gathering) and follow-up (Feedback) requirements for evaluations do NOT require PA;
- All psychotherapy (bio-psycho-social assessment, individual, family, and group therapy) services for children younger than three (3) years of age;
- Psychotherapy services for beneficiaries aged 3-20 that exceed the service standards. ~~outlined in Section 21.15 of this manual;~~ Refer to Section 21.15, Limitations to Service Provision;
- Day Treatment for all beneficiaries;
- ~~Case Management for all beneficiaries.~~

PA Process

A Medicaid Provider may request prior authorization for ~~any~~ services by submitting a Plan of Care (POC) form (MA-1148).

~~If services have been given PA by DOM but additional services are needed within the same fiscal year, authorization for these services may be requested by submitting an Addendum to Plan of Care (APOC) form (MA-1148A). Both forms are available through DOM's fiscal agent. Instructions for completing these forms are provided below. POC and APOC forms should be submitted to:~~

~~Division of Medicaid~~
~~239 N. Lamar St.~~
~~Robert E. Lee Bldg., Suite 801~~
~~**Mental Health Services - ORP**~~
~~Jackson, MS 39201-1311.~~

If services have been given PA by DOM but additional therapeutic services are needed within the same fiscal year OR evaluative services require more hours of assessment than were originally requested or a longer time frame in which to complete the evaluation, then the provider should request the extended services/time by submitting an Addendum to Plan of Care (APOC) form (MA-1148A).

Both the POC and APOC forms are available through DOM's fiscal agent. Instructions for completing these forms are provided below. POC and APOC forms should be submitted to the current address for the Division of Medicaid, which may be found on the DOM website at www.dom.state.ms.us, and directed to the attention of Mental Health Services.

POC/APOC forms will be reviewed and a determination made by DOM. A copy of the form, with the determination noted and a Medicaid-authorized signature affixed, will be returned to the provider. If services are approved, the form number (upper right) becomes the PA number (EPxxxxxx) which the

provider uses to bill DOM. Evaluations that are approved will be given a three-month authorization. The evaluation must be completed within the three month time frame in order to be eligible for reimbursement by DOM, unless a time extension is justified/ approved through submission of an APOC form.

~~The provider must obtain prior authorization from DOM at least two (2) weeks before psychotherapy services standard are exceeded.~~

Only one provider may be authorized to provide a particular service at a time. If, when a PA request is received, it is determined that another PA for that service is already on file for another provider, the requester will be asked to provide documentation (in the form of a signed statement from the beneficiary's parent/guardian) verifying the desire to change from the old provider to the new provider.

If a beneficiary is expected to need more therapeutic services than are available to him/her, the provider should request the PA of additional services at least two (2) weeks prior to the expected need.

It is the provider's responsibility to secure authorization from DOM before providing any service which requires PA. In case of an emergent situation, the provider should fax a copy of the request form to DOM at 601-359-1383. Tentative approval for service delivery may be granted depending on the circumstances, but the final approval upon which reimbursement depends cannot be given until the original copy of the PA request is received.

Completing the Plan of Care Form (MA 1148)

Section 1: Provider Information.
This must be completed with information about the Medicaid mental health service provider who plans to provide the service(s) for which prior authorization is being sought. Line 1 of this section (Name of Physician) should contain the name of the service provider, ~~whether s/he is a physician or other provider,~~ and the provider number under which the service will be billed.

Section 2: Medical Data.
Lines A, B (if applicable) and C ~~need not~~ should be completed when requesting day treatment services or psychotherapy services for beneficiaries age 3-20 that exceed the yearly standards. Lines A, B, and C need not be completed for psychotherapy services for a child under age 3 or for any evaluative service request.

Line D **MUST** contain a statement indicating why the child needs the mental health service(s) in question. Justification for services beyond the standard allotments (daily or annual) may be included here or attached separately if additional space is needed.

Section 3: Patient Information.
The minimum information required in this section is:

Name of Child
Child's Medicaid ID Number
Child's Date of Birth
The Name and **either** phone number (preferable) **or** address (if there is no phone) of the party who is responsible for the child

All other information in this section is optional.

Section 4: Services Requested.
This section should contain only those services intended to be provided by the servicing provider listed in Section I. For each service for which PA is being requested, one line in this section should contain: ~~Only one provider may be authorized to provide a particular service at a time. If more than one provider requests to provide a specific service (e.g. two POC's are submitted requesting day treatment, case management, evaluative services for a beneficiary by two different providers), the one with the most recent date will be honored. Any other PA's already in effect for that service will be revised to reflect an~~

~~earlier end date.~~

~~For each service for which PA is being requested, one line in this section should contain:~~

- The **abbreviation** for the service being requested. Acceptable abbreviations for the mental health services covered in this manual are: Ind/Fam/Gp Therapy, Psych Eval, Dev Eval, Neuropsych, Case Mgmt, Day Tx);

- The number of service units being requested for the remainder of the fiscal year (July1- June 30);

- ~~The number of service units being requested (if known). If PA is being sought for units that exceed the daily or annual standard, the provider should specify which standard s/he seeks authorization to exceed and the amount of "over-run" s/he expects to require.~~

  ~~Example 1: A child's family needs 2 hour (8 units) family therapy sessions. The daily standard is 6 units. One line in the section would read: "Fam therapy, +2 daily units, W3310".~~

  ~~Example 2: A child has used most of his annual standard of 144 individual therapy units. The therapist expects that the child will need a total of 176 units of individual therapy before the end of the fiscal year (a difference of 32 additional units). One line in this section would read "Ind therapy, +32 annual units, W3305".~~

- The code for the service.

Below the last service request, the provider MUST identify the date s/he wishes the service authorization to begin. This line would read "Start date = xx/xx/xx". The provider should submit requests for additional services at least two weeks prior to the expected need.

Sections 5 and 6 are for use by Medicaid.

Section 7: Certification of Medical Necessity.
This must be signed by the provider who will deliver the services (not necessarily a physician or nurse practitioner) for which authorization is being requested. By signing and dating the form, the provider is attesting to the medical necessity of the requested services. If there is a change of servicing provider within the same provider group (after approval has been given for the service but before the service has been provided), the new provider should countersign the approved PA form and fax a copy of the form to DOM at 601-359-1383.

Completing the Addendum to Plan of Care Form (MA 1148A)

Block in Upper Right Corner: Enter the PA number from the original POC.

Section 1: Provider Information.
This must be the same provider who signed the original POC form. Enter the provider's name. Any other information is optional.

~~**Section 2**: Medical Data. Enter the diagnosis by name and ICD-9 code. At least one diagnosis is required (Line A); others may be given if applicable (Line B). Lines C & D are not required.~~

Section 2: Medical Data
Lines A, B (if applicable) and C should be completed for all psychotherapy services. Lines A, B and C need not be completed for evaluative services. Line D need not be completed, as a statement of justification must be provided in Section 4, Medical Necessity.

Section 3: Patient Information.
Complete all information requested: the child's name, Medicaid number-and date of birth.

Section 4: Medical Necessity.
Complete a summary statement explaining why additional **service** units are needed within the time period already authorized. When additional time is being requested for an evaluation, the provider should state BOTH why the evaluation was delayed beyond the initial three months ("not enough time provided" will not be considered adequate justification) AND the facts which establish that medical necessity still exists. In either case, the provider should include any factors that have a bearing on the request, e.g., events that have caused set-backs or delayed progress. The justification statement may be continued on a separate paper if needed.
~~The justification statement should also address other factors that have a bearing on this request, e.g., events that have caused set-backs or delayed progress.~~

Section 5: Services Requested.
Each line should contain the abbreviation for the service being requested (e.g., Ind/Fam/Gp Therapy, Case Mgmt), the number of additional service units being requested, and the code for the service.

Sections 6 and 7 are reserved for Medicaid use.

Section 8: Certification of Medical Necessity. T
his must be signed by the provider who will deliver the services (not necessarily a physician or nurse practitioner) for which authorization is being requested. By signing and dating the form, the provider is attesting to the medical necessity of the requested services.

Division of Medicaid State of Mississippi Provider Policy Manual	New: X Date: ~~08/01/03~~ Revised: X Date 03/01/07 Current:
Section: Community-Based Mental Health Services Subject: Clinical Record Review Process	Section: 21.18 Pages: 2 Cross Reference: Therapeutic Services Record Review 21.19 Psychological Services Record Review 21.20

Purpose and Goals

The purpose of a clinical record review is to verify that a provider is in compliance with applicable state and federal requirements for mental health treatment and to monitor the quality of treatment being provided to Medicaid beneficiaries.

The goals of clinical record review are:

1. to assess the appropriateness and quality of mental health services being provided to Medicaid beneficiaries, and
2. to give clear, specific feedback regarding review findings to mental health service providers so that services may be enhanced.

Record Selection

Beneficiary records will be selected several times a year for review by DOM, Division of Mental Health Services. Some records will be selected because dates/amount of services billed indicate a pattern of intensive treatment. Other records will be selected randomly.

Provider Notification

Providers whose clients have been identified for record review will be notified by letter. The notification letter will indicate which components of the clinical record should be copied and submitted for review. Records must be submitted by parcel post delivery service (UPS or FedEx) or personally delivered by a specified date, which will be 5-7 calendar days from the date of the notice.

Record Review

- **Therapeutic Services** (individual, family and group therapy, ~~and case management~~) will be reviewed for compliance with the standards outlined in ~~Section 21.11~~ 21.19, CBMHS Therapeutic Services Record Review.
- **Psychological Evaluations** will be reviewed for compliance with the standards outlined in Section ~~21.12,~~ 21.20, CBMHS Psychological Evaluation Record Review.

Provider Feedback

Providers will be notified of the general results of the review within 30 calendar days after their record submission. Feedback will be given in the form of a letter mailed to each provider. The review outcome will be categorized as:

- SATISFACTORY
  The provider's name will be removed from the random selection pool for the next review period, insuring that the provider will not be ~~required~~ randomly selected to submit any further records for at least twelve months. However, if any of the provider's dates/amount of services billed indicate a pattern of intensive treatment, ~~the provider's records may be selected in spite of a satisfactory review~~ those records may still be selected for review, regardless of a satisfactory outcome of the previous review.

- ~~MORE INFORMATION NEEDED~~ CONTINUED REVIEW
  This is an interim outcome only. Reviewers may require additional records from a particular provider or more information regarding a particular case before determining the results of a review. If this is the case, the provider will be contacted and asked to submit the additional documentation within 14 calendar days of the request. In this case, the

provider will be notified of the final results of his/her review within 30 calendar days after the last document submission.

- IMPROVEMENT NEEDED

  Minor Improvements are needed. The provider's letter will contain information about what improvements are required. His/her name will remain in the selection pool during the subsequent 12 months.

  Substantial Improvements are needed. The provider's letter will contain information about what improvements are required. The provider will be pre-selected for further record review in the next review period.

- UNSATISFACTORY
  The provider will be informed by letter regarding further action.

Appeals Process

If a provider is dissatisfied with the final results of a record review or has a complaint about the review process, he/she should address his/her concerns in writing within 30 calendar days of the date of his/her status determination to the:

Director, Division of Mental Health Services
Bureau of Long Term Care
Division of Medicaid.

If the provider is dissatisfied with the results of this appeal, he/she should request an administrative hearing in writing within 30 calendar days to the:

Executive Director
Division of Medicaid.

Division of Medicaid **State of Mississippi** **Provider Policy Manual**	**New: ~~X~~** **Date: ~~08/01/03~~** **Revised: X** **Date: 03/01/07** **Current:**
Section: Community-Based Mental Health Services **Subject: Therapeutic Services Record Review**	**Section: 21.19** **Pages: 3** **Cross Reference: Consent to Bill Medicaid 21.09**

Provider _____ # _____ Beneficiary _____ #_____
Reviewer _____ Date _____

Records of Therapeutic Services (Therapy and Case Management) will be reviewed for compliance with the standards outlined below. Some of the items are rated on a simple "Yes(Y)/No(N)" basis. Other items are rated on the basis of "Satisfactory(S)/Improvement Needed (I)/Unsatisfactory(U)," depending upon either the *frequency* or *quality* of compliance documented by the record.

ITEM	ADMINISTRATIVE	RATING
1	Records were submitted in timely manner	Y N
2	Records were organized, could be easily reviewed	Y N
3	Consent for treatment properly executed	Y N
4	Consent to bill Medicaid properly executed	Y N
5	Session notes match billing data	S I U
	MEDICAL NECESSITY	
6	Clinical record (intake info, treatment plan and/or notes) indicate that some type of mental health services are medically necessary ____child has significant stressors, needs support ____child is at risk for more restrictive interventions if treatment is not provided now ____strengthening coping/social skills now is proactive towards preventing future deterioration ____a treatment need has been identified by the child/family	Y N
7	Treatment method/techniques used are appropriate to stated problems, in accordance with good practice standards	Y N
8	The amount/frequency of treatment is appropriate/medically necessary, given the nature/severity of the child's problems	Y N
	SERVICES	
	Bio-Psycho-Social Assessment	
9	Identifies presenting problem/problem history	S I U
10	Documents family background	S I U
11	Documents medical history	S I U
12	Documents educational information	S I U
13	Documents history of previous mental health treatment	S I U
14	Contains clinician's assessment/recommendations	S I U
	Treatment Planning	
15	Plan was developed by date of third therapy session	Y N
16	Plan contains a multi-axial diagnosis	Y N
17	Plan identifies the child's and/or family's strengths	S I U
18	Plan identifies clinical problems on which treatment will focus	S I U
19	Plan states treatment goals for each problem	S I U
20	Treatment objectives are given for each goal	S I U
21	Objectives have target dates for achievement	S I U
22	Treatment modalities and/or strategies are identified for each objective	S I U
23	Plan is signed/dated by provider AND client and/or client's family member	Y N
24	Plan is updated/revised every 3 months	Y N N/A

Provider _____ # _____ Beneficiary _____ #_____

Reviewer _____ Date _____ Reviewer _____ Date _____

	Service Notes (Therapy and Case Management)	
25	Include the date of service	S I U
26	Include the time of day the service was provided	S I U
27	Identify the type of service provided	S I U
28	Include the length of time spent delivering the service	S I U
29	State who received or participated in the service	S I U
30	Relate to the treatment plan/case management service plan	S I U
31	Give a summary of what transpired in the session	S I U
32	Authenticated by signature/initials of service provider	S I U
33	Travel time documented separately (Case Mgt)	S I U N/A
	Beneficiary/Family Member Interview	N/A
34 33	Child/family can identify the problem for which services were sought	S I U
35 34	Child/family understand what goals of treatment are/were	S I U
36 35	Child/family understand/agree with strategies employed in treatment	S I U
37 36	Child/family understand/agree with frequency of treatment sessions	S I U
38 37	Child/family understand/agree with duration of therapy	S I U
39 38	Family are/were included in treatment, given guidance or recommendations to help child	S I U
40 39	Child/family understand/agree with criteria for termination of therapy	S I U
41 40	Child/family members have a positive perception of therapist, feel progress is being/was made and can explain why	S I U
42 41	Child/family members feel they were treated with respect	S I U
	Therapist Interview	N/A
43 42	Therapist is able to articulate his/her philosophy of treatment	S I U
44 43	Therapist can identify the problem for which services were sought in this case	S I U
45 44	Therapist can explain his/her treatment strategy in this case	S I U
46 45	Therapist can explain/justify the frequency of treatment sessions	S I U
47 46	Therapist can explain/justify the duration of treatment	S I U
48 47	Therapist can relate guidance/recommendations given child's family	S I U
49 48	Therapist can explain/justify criteria for termination of treatment	S I U
50 49	Therapist worked cooperatively with interviewer(s) regarding this case	S I U

~~Provider~~ _____ ~~#~~ _____ ~~Beneficiary~~ _____ ~~#~~ _____
~~Reviewer~~ _____ ~~Date~~ _____ ~~Reviewer~~ _____ ~~Date~~ _____

A brief explanation of the rating items follows:

1-3. Self-explanatory.

4. **Consent to bill Medicaid properly executed** – A sample "consent to bill Medicaid" form is provided in Section ~~21.13.~~ 21.09

5. **Session notes match billing data** – If any discrepancy is found between billing and documentation of sessions (i.e. no documentation is found for a session for which Medicaid was billed), additional beneficiary records will be requested for review to determine whether the discrepancy was merely an oversight or a pattern of inadequate documentation exists. If a pattern is found, the provider will be referred to Program Integrity for investigation.

6. **Clinical record (intake info, treatment plan and/or notes) indicates that some types of mental health services are medically necessary** – The list of justifications for medical necessity given here is representative but not exhaustive.

7. **Treatment method/techniques used are appropriate to stated problems, in accordance with good practice standards** – Even if the child's need for *some* form of mental health treatment is clear, the type of treatment being provided must be appropriate to the nature/severity of the child's problems in order to pass the "medical necessity" test.

8. **The amount/frequency of treatment is appropriate/medically necessary, given the nature/severity of the child's problems** – The length and frequency of treatment sessions, as well as the duration of the treatment process over time, must be consistent with the nature/severity of the child's problems. At a minimum, the provider will be required to repay any monies disbursed for services which are judged to be in excess of medical necessity

9-14. The bio-psycho-social assessment is the basic "intake assessment" which a clinician does at the outset of treatment. It must include, at a minimum, the information identified here including any psychological evaluations that have been administered.

15. The treatment plan should be completed and signed by the clinician and the child and/or family member by the date of the third therapy session.

16-22. Self-explanatory.

23. The treatment plan should be completed and signed by the clinician and the child and/or family member by the date of the third therapy session.

24-32. Self-explanatory.

~~**33.** **Travel time documented separately (Case Mgt)** – Case Management documentation should specify the amount of time spent in service delivery and the amount of time spent in travel to/from the site of service.~~

~~**34-50.**~~ Beneficiary/family and/or therapist interviews will not be conducted as a part of every review.
33-49 When they are included, these are the items on which those portions of the review will be rated.

Provider _____ # _____ Beneficiary _____ # _____
Reviewer _____ Date _____ ~~Reviewer~~ _____ ~~Date~~ _____

Records of Psychological Evaluations will be reviewed for compliance with the standards outlined below. Some of the items are rated on a simple "Yes(Y)/No(N)" basis. Other items are rated on the basis of "Satisfactory(S)/Improvement Needed(I)/Unsatisfactory(U)," depending upon the quality of compliance documented by the record.

ITEM	ADMINISTRATIVE	RATING
1	Records were submitted in a timely manner	Y N
2	Records were organized, could be easily reviewed	Y N
3	Consent for treatment properly executed	Y N
4	Consent to bill Medicaid properly executed	Y N
5	Billing data match information in the clinical record	Y N
	MEDICAL NECESSITY	
6	Medical necessity for this evaluation is documented or clearly evident ___there is a history of unexplained treatment failures ___there are questions that an eval might help to answer (the "referral question") ___uncertainties about diagnosis and/or treatment ___unexplained learning problems when child doesn't qualify for SpEd evaluation ___need to assess child's potential for success in a particular type of program ___child was placed in DHS custody WITHIN 90 DAYS prior to the assessment date ___eval required by DOM for admission to a PRTF	Y N
	SERVICES	
7	Pre-eval background/information gathering session is documented	Y N
8	Report giving results of the evaluation is in clinical file	Y N
9	Report is completed within 30 days of completion of the assessment	Y N
10	Evaluative tools (tests, rating instruments, etc.) utilized were appropriate to referral question, the unique characteristics of the child, and the testing situation	S I U
11	Report is a synthesis of information gleaned from testing, observation, interviews with child/family, collateral contacts	S I U
12	Report adequately addresses the referral question	S I U
13	Report reflects an understanding of the child's/family's strengths	S I U
14	Report contains practical recommendations for those working with the child	S I U
15	Report is signed by psychologist who conducted the evaluation	Y N
16	Post-eval feedback to family (and child, if appropriate) is documented	Y N
17	Post-eval feedback to referral source is documented	Y N N/A
18	Post-eval feedback to family/child and/or referral source includes information about how to implement the psychologist's recommendations	S I U
19	Date and amount of time spent assessing the child (interviews, testing, etc.) is documented in the clinical record	Y N
20	Date and amount of time spent preparing the report is documented in the clinical record	Y N

A brief explanation of the rating items follows.

1-3. Self-explanatory.

4. **Consent to bill Medicaid properly executed** – A sample "consent to bill Medicaid" form is provided in Section ~~21.13~~ 21.09

5. **Billing data match information in the clinical record** – If any discrepancy is found between billing and documentation of services is found, the provider may be asked to submit additional records for review. If a pattern of inadequate or improper documentation is found, the provider will be referred to Program Integrity for investigation.

6. **Medical necessity is documented or clearly evident** – There should be clear evidence either by history or by documented observation that a psychological evaluation is necessary to answer the referral question. The following are indicators of medical necessity (this list is representative, but not exhaustive):

There is a history of unexplained treatment failures – child has participated in a number of types of treatment with limited success.
There are questions that an evaluation might help to answer, AND AN EVALUATION IS THE MOST APPROPRIATE WAY TO ADDRESS THE REFERRAL QUESTION. In order to determine this, the referral question must first be very clearly defined (e.g., "to determine if psychotic symptoms are interfering with functioning" versus "doesn't get along"). If it is then apparent that the referral question can be answered through less intrusive and time consuming means (e.g., diagnostic interview, behavioral interventions, referral to physician if medication was stopped by family and symptoms re-emerged), these interventions should be made and testing should not be pursued. Examples of referral questions that would likely indicate that testing is warranted include (this list is representative, but not exhaustive):

Uncertainties about diagnosis and/or treatment – child is exhibiting significant symptoms (e.g., depression, psychosis, severe acting out) of unclear etiology and an evaluation of those symptoms would aid in treatment planning. In general, symptoms of ADHD, in and of themselves, are not considered sufficient basis for a psychological evaluation, unless it is clearly evident that less intrusive interventions such as behavioral approaches and parent education have been attempted and were not successful.

Unexplained learning problems when a child does not qualify for Special Education (SpEd) evaluation – learning style or difficulties are interfering with school performance or psycho-social functioning in non-educational settings. Children who appear to be eligible for SpEd services should be referred to the school system for evaluation.

Need to assess child's potential for success in a particular type of program – an assessment of child's intellectual and/or psychological functioning would be helpful in determining if he/she would benefit from a particular program.

Child was placed in DHS custody WITHIN 90 DAYS prior to the assessment date – self explanatory. Routine assessments of children in custody for longer than 90 days will not be reimbursed unless medical necessity is clearly evident and documented.

Evaluation required by the Division of Medicaid for admission to a psychiatric residential treatment facility –self explanatory

7. **Pre-eval background/information gathering session is documented** – This session should be conducted separate and apart from the evaluation, unless to do so would pose a hardship for the family and/or child. Medical necessity for the evaluation should be determined in this session, and a summary of the session should be documented either in case notes or in the evaluation report. This session should also serve as a means to stop duplication of services by gathering information on psychological evaluations previously administered.

8-9 **Self explanatory**

10. **Evaluative tools utilized were appropriate to the referral question, the unique characteristics of the child, and the testing situation** – Instruments should clearly address the referral question, and be psychometrically sound (recognized as having good reliability and validity). It should also be clear that the examiner has considered the unique characteristics of the child (e.g., how verbal the child is, the child's primary language, etc.) and the demands of the testing situation (e.g. a child being tested in an office primarily staffed by people of different ethnicity and possibly feeling intimidated, a child being tested within days of being taken into custody, a child being tested at a group home and possibly distracted by noise, etc.) both in choosing instruments and interpreting results. ***Examiners are cautioned to avoid administering the same battery of instruments to all referrals without giving significant consideration to the factors discussed in this section.***

11. **Report is a synthesis of information gleaned from testing, observation, interviews with child/family, collateral contacts** – The report should not be merely a recitation of data and facts. Rather, it should pull together information from all sources and generate logical and helpful conclusions from that information. It should be evident that attempts were made to gather information from all relevant sources (e.g. if the referral question relates to school, contact should be made with relevant school personnel). Computer-generated reports or recommendations are not considered an adequate synthesis of information.

12. **Report adequately addresses the referral question** – Each step of the testing process (information gathering, test selection, test administration, interpretation, recommendations and feedback) should relate back to the referral question. For example, if the referral question relates to depression, and the report focuses primarily on intellectual and achievement testing, it is highly unlikely that the referral question has been adequately addressed. When a test can be given for a variety of reasons (e.g., an I.Q. test), the report should clearly explain the purpose of the test for this particular evaluation. Examiners are cautioned against using generic lists of recommendations – recommendations should be specifically tailored to the referral question and the unique characteristics of the child and family.

13. **Report reflects an understanding of the child's/family's strengths** – The report should not only address needs of the child and family, but also recognize strengths. Strengths should serve as a guide in synthesizing information and formulating recommendations. Strengths include individual characteristics (e.g., artistic ability), as well as cultural and/or family values (e.g., strong religious identification) and available resources (e.g., extended family support).

14. **Report contains practical recommendations for those working with the child** – Recommendations should relate to the referral question, be practical, and reflect an understanding of the child's/family's values, resources and possible limitations.

15. Self explanatory.

16-17 **Post eval feedback to family (and child, if appropriate) and referral source is documented** – Case records should indicate that this feedback occurred, and provide a summary of it.

18. **Post eval feedback to family/child and/or referral source includes information about how to implement the psychologist's recommendations** – Documentation of these sessions should reflect that the psychologist insured that the family/child and/or referral source understood the recommendations and were assisted in developing a plan to implement them. For example, if the psychologist recommends a helpful book to parents, the psychologist should insure that the book is on the parent's reading level and that they have the resources to obtain it. Similarly, if a specific type of therapy or activity (e.g., after school program) is recommended, the psychologist should provide contact information for those resources and be sensitive to any financial constraints the family might have in pursuing those options.

19-20. Progress notes, test reports and billing records should accurately reflect when all phases of testing, scoring and report writing were completed.